STATE OF RHODE ISLAND AND PROVIDENCE PLANTATION
BEHAVIORAL HEALTHCARE, DEVELOPMENTAL DISABILITIES, AND HOSPITALS
DIVISION OF DEVELOPMENTAL DISABILITIES
6 HARRINGTON ROAD – SIMPSON HALL
CRANSTON, RI 02920
(401) 462-3421

APPLICATION FOR SERVICES

Internal Use Only

1. PERSONAL INFORMATION:

Applicant's Name: _____ **Date of Birth:** _____

Residence Address: _____
Street Apt./Floor City State Zip

Mailing Address: _____
(if different from residence) Street/PO Box Apt./Floor City State Zip

Telephone: _____ **Social Security #:** __ __ __ - __ __ - __ __ __ __

DCYF involved: Yes ❑ No ❑ **Final date of high school:** *(including Transition Academy)*_____

Marital Status: Never Married ❑ Married ❑ Divorced ❑ Separated ❑ Widowed ❑

Maiden Name: (*if applicable*) _____ **Gender:** Male ❑ Female ❑

Racial/Ethnic Heritage: White (non-Hispanic) ❑ Black (non-Hispanic) ❑ Hispanic ❑

Asian or Pacific Islander ❑ American Indian or Alaskan Native ❑ Other ❑ _____

Do you or any member in your household speak English? Yes ❑ No ❑ *If "No"*, what is the primary language spoken? _____

Living Arrangement: Live Alone ❑ With Family ❑ Group Home/Residential ❑ Other ❑ _____

Parent/Caregiver's Name and Date Of Birth: _____

Parent/Caregiver's Name and Date Of Birth: _____

Name of Primary Physician/Health Care Provider: _____

Address:_____ Telephone: _____

Medicaid: Yes❑ No❑ Medicare: Yes❑ No❑ Other Health Insurance: _____

2. PLEASE INDICATE APPLICANT'S DISABILITY/DISABILITIES:

(Please provide disability names and/or descriptions)

_____

_____

Age When Disability/Disabilities Began: _____

3. PLEASE CHECK ALL AGENCIES WITH WHOM YOU HAVE BEEN INVOLVED:

❑ DCYF ❑ Special Education ❑ ORS ❑ PARI ❑ DHS ❑ Crossroads

❑ Child Dev Ctr (CDC) @ RI Hospital ❑ Psychiatric Hospitalizations:_____

❑ School(s) - Name/Address/Telephone: _____

_____

❑ Mental Health Services - Name/Address/Telephone: _____

_____

❑ Other Agencies - Name/Address/Telephone: _____

_____

_____

OVER PLEASE→

4. SOURCE OF INCOME: Please provide recent work information.

Are You Currently Employed? Yes ❑ No❑ If 'Yes', please provide the employer's name and address below:

_____

Applicant's Gross Pay: (please indicate one)	**Does the applicant receive:**	
Annual $ _____.00 (amount earned per year)	**SSI:** Yes ❑ No ❑ (government check on 1st of month)	Amount Per Month $_____.00
Bi-Weekly $ _____.00 (amount earned every two weeks)	**SSDI/RSDI:** Yes ❑ No ❑ (government check on 3rd of month)	Amount Per Month $_____.00
Weekly $ _____.00 (amount earned every week)	**Other income source:** (e.g. child support, alimony, trust fund. Etc.)	Amount Per Month $_____.00

5. SERVICES REQUESTED THROUGH THE DIVISION OF DEVELOPMENTAL DISABILITIES:

❑ **Case Management –** Services of a Social Worker through the Division to assist in accessing supports.

❑ **Employment/Day Supports –** Supports to assist the individual in supported employment, volunteer experiences, or recreational and social activities.

❑ **Community Supports –** Direct support and assistance for participants, or for the relief of the care giver, in or out of the participants residence.

Residential Supports:

❑ **Immediate residential services** BHDDH - QI involvement due to abuse or neglect, police, attorney general's office or DCYF decision that warrants a removal and placement in residential setting, individuals in hospitals or time-limited rehab requiring 24 hr residential setting at discharge, youth in residential setting when turning 21, medically fragile primary caretaker, temporary setting follow the incapacitation or death of primary caretaker.

❑ **Future residential services.** Individual may need or want residential services in the future.

❑ **Home Modifications –** Changes in the home to enhance the individual's ability to be independent.

❑ **Assistive Technology** – Devices to assist the individual with personal care, communication and mobility.

6. DO YOU HAVE A COURT-APPOINTED GUARDIAN? Yes ❑ No ❑

If "Yes", please complete the information below as well as enclose a copy of the Probate Court's Appointment of Guardianship paperwork

Name: _____Relationship: _____ Telephone: _____

Address/City/State/Zip: _____

7. DID YOU NEED HELP IN COMPLETING THIS FORM? Yes ❑ No ❑ ***If "Yes":***

Name: _____Relationship: _____ Telephone: _____

WHO REFERRED YOU TO BHDDH? _____

8. DO YOU WANT SOMEONE WITH YOU DURING AN INTERVIEW WITH THE DIVISION'S STAFF? Yes ❑ No ❑ If "Yes" and the person you'd like with you during the Division's staff interview is different than the person listed above, please provide his/her name, relationship, and telephone number below:

Name: _____Relationship: _____ Telephone: _____

**** THIS APPLICATION MUST BE SIGNED & DATED BELOW ****

- If the applicant has a court-appointed guardian, the guardian must sign and date below.
- If the applicant is unable to sign his/her name, his/her advocate or authorized representative or parent may sign.
- If the applicant is under age 18, both the applicant and his/her parent must sign the application.

_____ Date:_____

(Signature of Applicant)

_____ Relationship:_____ Date:_____

(Signature of Advocate/ Authorized Representative/Parent)

_____ Relationship:_____ Date:_____

(Signature of Court-Appointed Guardian, if applicable)